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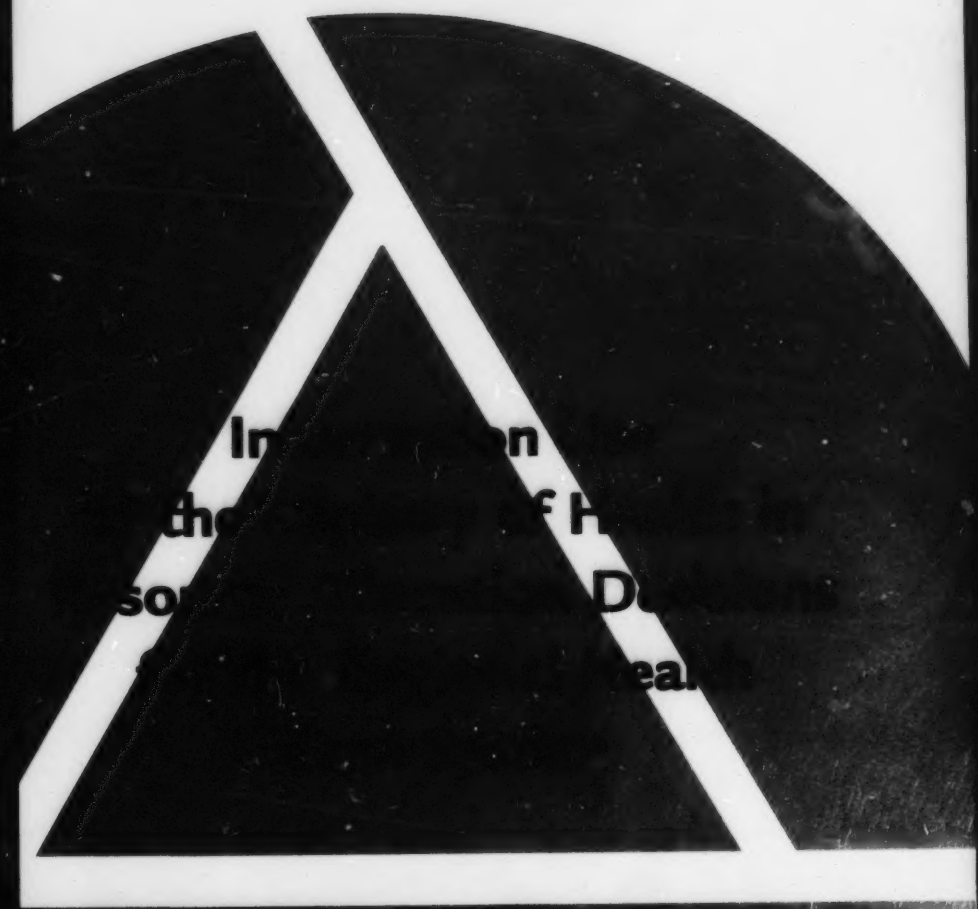

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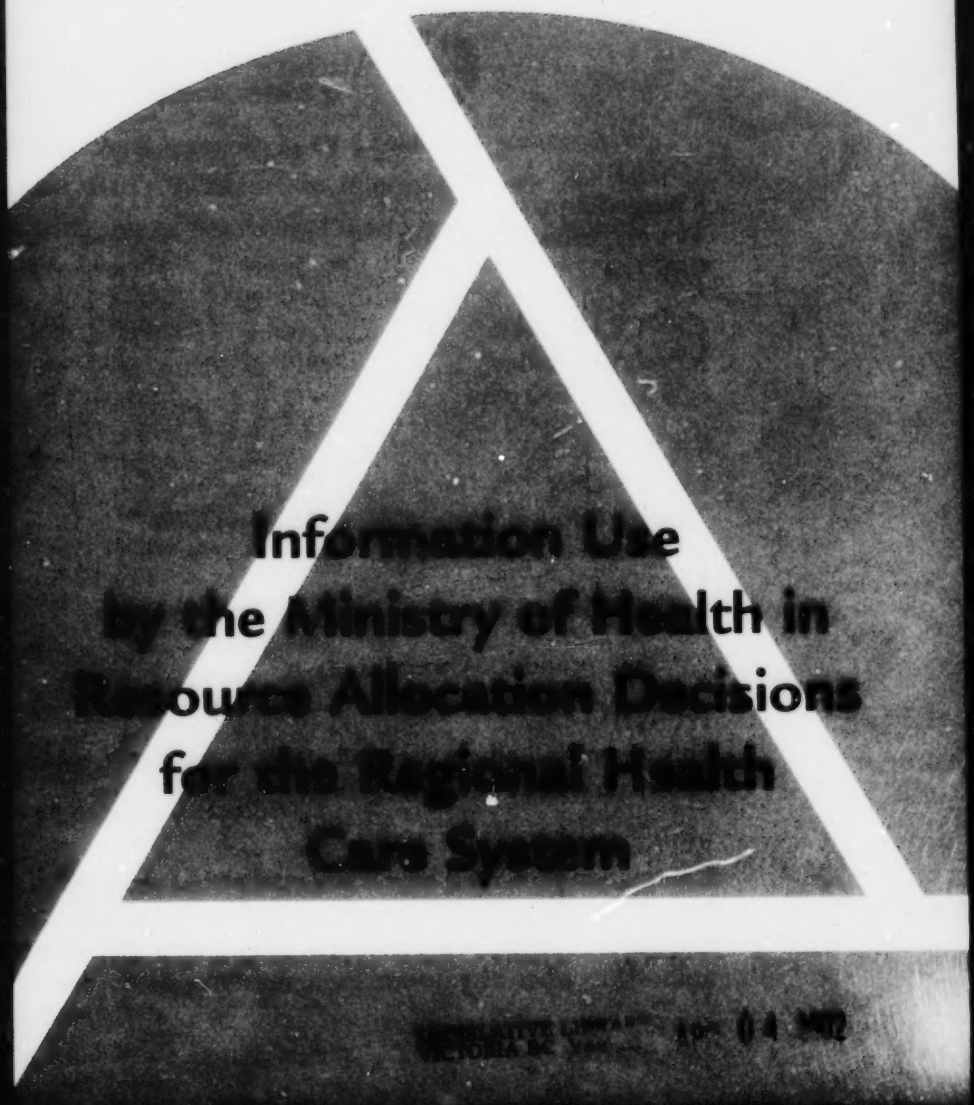

Information Use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System

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The Honourable Claude Richmond
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
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Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2001/02 Report 6: Information use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System.

Wayne Strelioff

Wayne Strelioff, CA
Auditor General

Victoria, British Columbia
March 2002

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

102-0

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auditor general's comments

Like all provincial health care systems, British Columbia's is very complex and costly. In 2001/02 spending by the Ministry of Health is estimated to reach $9.5 billion, approximately 38% of the provincial budget. Almost 62%, or $5.9 billion is for regional programs and of that approximately $5.5 billion is for the regional health care system—those services provided by the health authorities and which include acute and continuing care, public and preventive health, and adult mental health. This does not include funds which flow to the health authorities from other areas of the ministry, such as the Alternate Payments Program.

With health care consuming such significant resources, it is important that the ministry make decisions about resource allocation using sound information on performance—that is, the extent to which stated goals and objectives are being met and principles safeguarded.

This audit focussed on the regional health care system, and examined whether the ministry is:

- using appropriate information to support its resource allocations to the regional health care system;
- establishing clear direction for the regional health care system, including principles, priorities and accountabilities; and
- assessing and reporting on the overall performance of the regional health care system, and providing information the health authorities need to assess and report on their own performance.

The audit examined the information used to support both planned and ad hoc resource allocation decisions in fiscal 1999/2000, to prepare for the 2000/01 and 2001/02 fiscal years, and to assess and report performance for both 1999/2000 and 2000/01 fiscal periods. We did not examine the information used to support the 2002/03 fiscal year health estimates.

We concluded that the ministry is allocating resources across the health care system without the benefit of essential cost and performance information. Instead, the ministry allocates resources based on historical spending levels. As a result, most resource allocation decisions are not based on the kind of information necessary to fully implement and evaluate the strategic directions the ministry has set for the health care system.

I believe that this lack of a clear connection between the ministry's resource allocation process and its stated strategic directions, combined with the lack of readily available and comprehensive information about the basis of its decisions, contributes to a funding system that is neither understandable or transparent.

We found that the ministry has established some foundations for setting direction. It has published broad principles, a three-year strategic directions document, and an accountability framework. However, there are significant problems. Each document has been developed independent of the others, and together they do not provide an effective overall framework to support resource allocation decisions or performance reporting.

We also found that the ministry's reporting on performance is weak. Although the ministry reports annually on the health status of British Columbians and on services provided, the information lacks clear links to what the ministry intended to achieve. As well, the ministry does not systematically monitor reporting compliance by the health authorities, thus limiting its ability to ensure it has accurate, relevant and timely information.

I am concerned that the ministry lacks the capacity to use information, and has not clearly articulated its information needs for the future. This may result in wasteful expenditures on information gathering, and an ongoing inability to link budget decisions to performance and strategic priorities.

I recognize that, as in other jurisdictions, information management in British Columbia's health care system has not been a priority because of other demands placed on the system. However, faced with new technologies and other cost drivers putting continued pressure on the system, the ministry will be hard pressed to know if it is spending too much, too little, or enough on health care. I believe that if the ministry is to fulfill its role as steward of the health care system it must clearly understand its information needs, obtain the information, and use it to make wise decisions about resource allocation and performance reporting.

I would like to take this opportunity to thank all those who cooperated with my Office to gather information for this report. As well, I would like to acknowledge the hard work, professionalism and dedication of my staff in the production of this report.

Wayne K. Strelioff, CA
Auditor General

Victoria, British Columbia
March 2002

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Review Team

Deputy Auditor General: Peter Gregory

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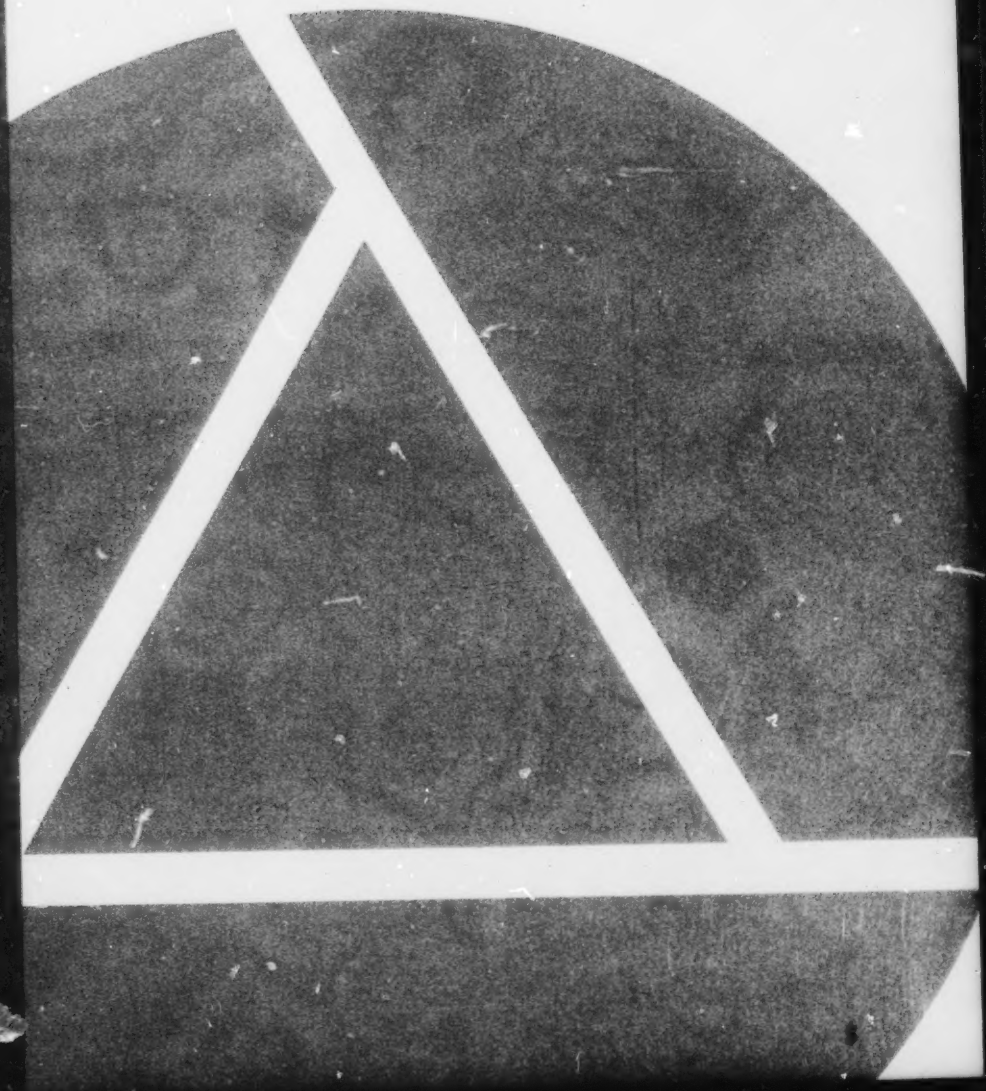
◆ ◆ ◆

highlights



highlights

Audit Purpose and Scope

The purpose of this audit was to assess whether the Ministry of Health uses appropriate information to allocate resources to the regional health care system.

Specifically, the audit examined whether the ministry:

- establishes clear direction, including principles, priorities and accountabilities for the regional health care system
- uses appropriate information to support resource allocations to the regional health care system
- assesses and reports on the overall performance of the regional health care system, and provides information the health authorities need to assess and report on their own performance.

The audit examined the information used to support both planned and ad hoc resource allocation decisions in fiscal 1999/2000, to prepare for the 2000/01 and 2001/02 fiscal years, and to assess and report performance for both 1999/2000 and 2000/01 fiscal periods. We did not examine the information used to support 2002/03 fiscal year health estimates.

We performed this audit in accordance with assurance standards recommended by the Canadian Institute of Chartered Accountants and accordingly included such tests and other procedures as we considered necessary to obtain sufficient evidence to support our conclusions. In collecting our evidence we reviewed documents prepared by the Ministry of Health, health authorities, and others. We also interviewed staff in the Ministry of Health, health authorities and other agencies.

Overall Conclusion

We concluded that the ministry is allocating resources across the health care system without the benefit of essential cost and performance information. Instead, the ministry allocates resources based on historical spending levels. As a result, most resource allocation decisions are not based on the kind of information necessary to fully implement and evaluate the strategic directions the ministry has set for the health care system.

Key Findings

1. The ministry provides direction to the regional health care system through various written documents, but there is no cohesive framework or clear measurable performance expectations

The ministry lacks a corporate systematic approach to accountability. Since regionalization in 1997, the Ministry of Health has developed a number of documents that are intended to define the direction and broad expectations for the regional health care system. However, the documents do not set out a cohesive framework with specific measurable performance expectations. The strategic directions document for 1999–2002 is broad, and lacking in specifics. In 1999/2000 the ministry developed a work plan to go along with it. However, the ministry did not evaluate what was actually accomplished. We also found that the strategic directions document was not used to support strategic decisions and choices as part of the budget development cycle or resource allocation process.

However, the regional health service plans that we reviewed adequately reflected the ministry's strategic directions, health goals and planning principles. As well, most of the health service plans established goals and objectives specific to both mental health and continuing care.

The ministry needs to establish continuity between its performance planning and that of the regions, in a single, cohesive framework that supports decision making at all levels.

2. Budget development and resource allocation processes and decisions are not supported by appropriate information or rigorous analysis

The ministry's budget is developed on the basis of historical spending levels. Good budgeting practice requires that more emphasis be given to the direction the ministry has established and how it wants to achieve its goals and objectives.

We found that issue papers developed to support the ministry's budget submission provide limited information and are often unsupported by rigorous analysis.

3. The ministry is developing a population needs-based funding model

A population needs-based funding model will be used by the ministry to allocate available funds to the health authorities, taking into consideration a number of factors such as population size, socio-economic status, and inter-regional referral flow. The model is not meant to determine total funding for the health care system, but only to provide a mechanism for allocating available funds. As well, the model will only be used in the allocation of funds available for those services and programs that are common to all health authorities and linked to population size and composition. Thus, funding for the Medical Services Plan, Pharmacare, and tertiary services (e.g., cardiac surgery and renal dialysis) are outside this allocation process.

However, even with these limitations, when implemented, this model should help make the process more understandable and transparent—attributes the current one lacks. The Ministry plans a phased introduction of the model, to reduce the impact on regions which would face a decrease in funding. In the current fiscal circumstances, this approach should be reconsidered.

4. Reporting by the ministry does not provide a complete picture of the performance of the regional health care system

The ministry's main mechanism for reporting on the performance of the regional health care system is its annual report. The 1999/2000 annual report was the first one the ministry was to issue that would report on the organization's achievements relative to its 1999–2002 strategic directions for the health services system.

We found no clear relationship between the measures reported on and the ministry's stated direction. The choice of indicators did not appear to be linked to any clear expectations of performance, and there was no financial information linking what was intended to be achieved with what was actually achieved for the dollars spent.

The Budget Transparency and Accountability Act, introduced in July 2000, calls for a focus on accountability for results, including comparing actual results for the preceding fiscal year with expected results identified in that year's performance plan.

Although the ministry's 2000/2001 annual report included an assessment of how well it did in achieving the goals of its 2000/2001 performance plan, the weaknesses we identified in the 1999/2000 report were still present.

5. Ministry monitoring of the health authorities should be improved

The ministry appears to lack the capacity to use the information it receives, and has not clearly articulated the information it needs to act as an effective steward of the system. With the arrival of a new governance and management system, it is crucial that the Ministry develop its capacity to set direction and monitor achievement through focused, mission-centred performance information.

The health authorities are expected to report specific financial and statistical information to the ministry on a defined basis. As well, they are required to submit their health service plans annually for ministry approval.

However, compliance by the health authorities with the financial and statistical reporting requirements has been a problem. Only recently have efforts been initiated to address the issue. Nevertheless, it is not clear who is actually responsible for monitoring health authority performance overall. Regional teams seem to have some responsibility, as do financial staff and some committees, but it is unclear who is to take action when issues are identified.

The health authorities are required by legislation to develop and submit health service plans. The Ministry of Health views these plans as a major accountability mechanism, yet we found that the ministry does not use them in any way to monitor the health authorities. It was also not very clear to us whether a review of achievements against the plan was given any consideration in the approval of the subsequent plan, or whether the ministry intended to use this information in its budget cycle or resource allocation process.

◆ ◆ ◆

recommendations

1. Direction and Expectations

The Ministry should:

- ***Define its information needs.***
- ***Set measurable performance expectations that support the ministry's strategic direction, and governance and resource allocation decisions.***
- ***Develop and publish an accountability framework for the regional health care system that describes roles, responsibilities and performance reporting expectations.***
- ***Issue health authority funding allocation letters prior to the beginning of the fiscal year.***
- ***Ensure that reporting is connected to the authorities' accountability.***

2. Use of Information

The Ministry should:

- ***Use information relative to goals and objectives and health system performance in developing its budget.***
- ***Develop an approach to information management that supports continuous quality improvement in performance of its governance and stewardship of the health care system.***
- ***Assess its capacity to use health information.***
- ***Ensure that the health data warehouse will meet its information needs.***
- ***Ensure that the proposed data warehouse does not duplicate an existing UBC system.***
- ***Develop the information systems capacity to provide the data to measure performance.***

3. Resource Allocation Model

The Ministry should:

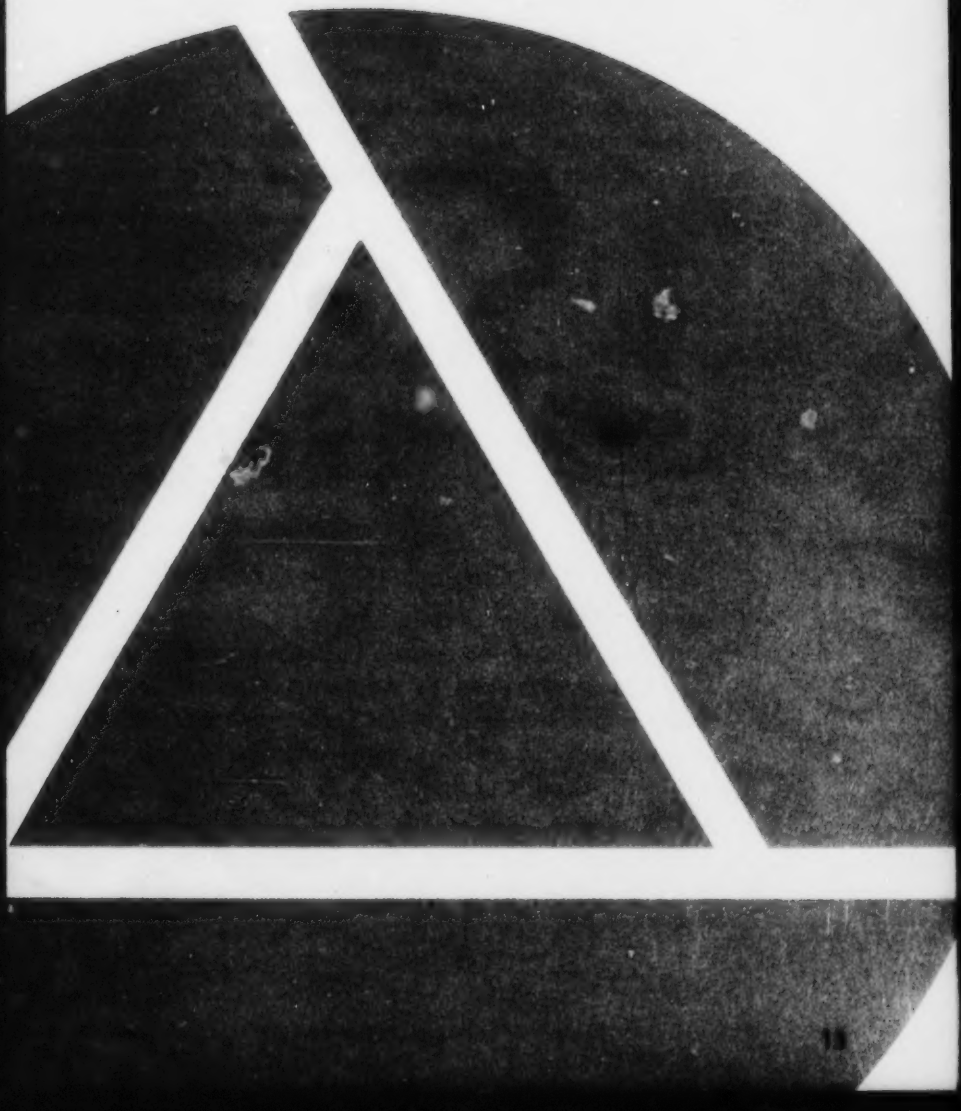
- ***Implement a resource allocation model that is transparent, understandable, and that links information about performance to resource allocation decisions and choices.***
- ***Introduce the budget reallocations based on the model on a more timely basis.***

4. Accountability Reporting

The Ministry should:

- ***Provide health authorities with reports on their performance and give them direct access to the information so that the health authorities can assess, monitor and compare their own performance to that of other health authorities.***
- ***Ensure that reports and information on health authority performance are available and accessible to the public.***
- ***Report on the aggregate performance of the system and the authorities, providing comparative and contextual information that will allow British Columbians to assess the cost-effectiveness of health care services.***

detailed report



background

In 1990, at the time the Royal Commission on Health Care and Costs began its examination of health services in British Columbia, the provincial government was spending approximately $5 billion in the health sector.

The commission was charged with determining how the existing system worked and what had to be done to improve it. It was asked to report its findings and make recommendations particularly with respect to structural changes, utilization management, application of technology, funding and reimbursement methods, service effectiveness and management efficiency.

The commission released its findings in the fall of 1991. It reported a serious lack of direction in health care in the province and a lack of local influence. It also noted a heavily centralized bureaucracy that separated the system from the people it served and was littered with barriers that reinforced inequities, discouraged initiative and stifled changes. The commission made numerous recommendations on all aspects of the system and identified the following as the necessary components of an effective, efficient health care system:

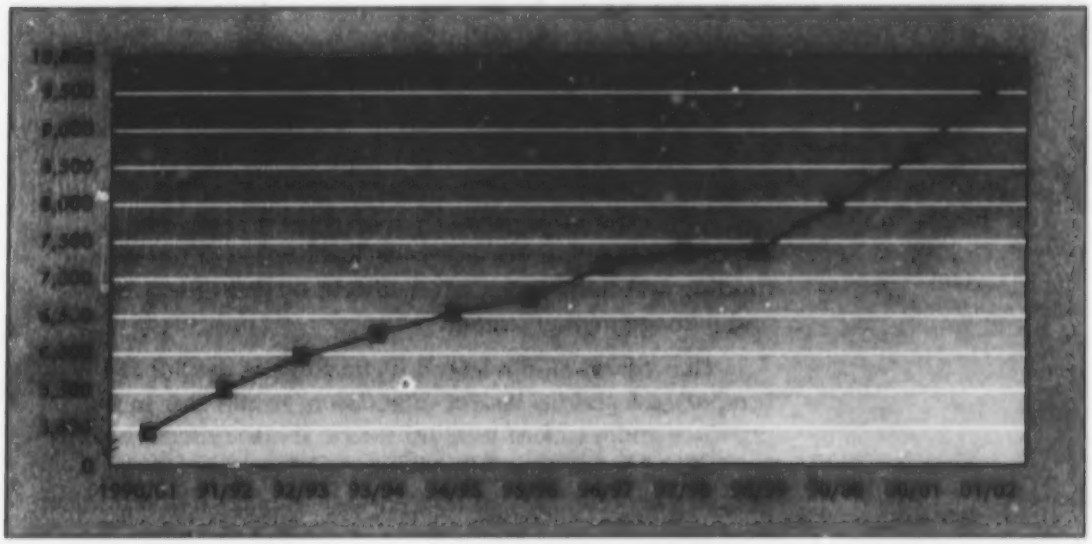
- operating closer to home;
- putting the public first;
- measuring outcomes;
- involving the community;
- funding to acceptable levels;
- breaking down walls to achieve an integrated system;
- providing necessary education;
- supporting volunteers; and
- increasing openness.

In the 10 years since the commission released its report, the government has introduced numerous changes to the health system. However, a number of the problems and issues identified by the commission still exist—notably, lack of openness, lack of outcome measurement, funding issues, and barriers to integration, even though health care spending continues to increase. In 2001/02, the Ministry is expected to spend approximately $9.5 billion for health services. Exhibit 1 provides a perspective of total health care spending by the Ministry for the 10-year period since the commission's report.

Exhibit 1

Total Health Care Expenditures by the Ministry of Health 1990/91 to 2001/02*

$ Billions



Source: British Columbia Public Accounts for 1990/91–2000/01; British Columbia Estimates for 2001/02*

New Directions

Following the release of the Royal Commission's report, the Ministry of Health undertook months of consultation with stakeholders and, in 1992, released *New Directions for a Healthy British Columbia.* This was the ministry's strategic plan for reforming the health system. The plan outlined a definition of health, a vision for a revitalized health system, and a mission statement to guide the process of change. It also established five priorities:

- Better health
- Greater public participation and responsibility
- Health brought closer to home
- Respect for the care provider
- Effective management of the new health system

From 1992 until the spring of 1996, reform proceeded. Twenty Regional Health Boards and 82 Community Health Councils were created, a labour adjustment strategy was introduced, new council and board members were provided

orientation and education sessions, and health and management plans were developed by the boards and councils. However, the process never advanced to the point of the boards and councils assuming responsibility for the health services within their jurisdictions.

During this same period, the role of the Provincial Health Officer was redefined by legislation and a set of interim health goals was developed and formed the basis of the Provincial Health Officer's annual report. In July 1997, Cabinet officially approved provincial health goals for the province, on which the Provincial Health Officer continues to report (see Appendix A). The Ministry of Health, in developing its strategic directions, gives consideration to the health goals. The health authorities are also expected to consider the health goals in developing their health service plans.

In June 1996, in light of a number of concerns raised about New Directions, the Minister of Health halted the process and ordered a review. The terms of reference of the review team emphasized the need to assess the cost-effectiveness of regionalization to ensure it would not affect the quality of health care services available in the province.

As a result of the review and its recommendations, New Directions was reconfigured as "Better Teamwork, Better Care."

Better Teamwork, Better Care

The stated goal of Better Teamwork, Better Care was "to improve health care for people." Its key priorities were:

- ensuring people's access to the service they need when they need it;
- providing the best possible quality of care;
- keeping hospital lengths-of-stay as long as needed but as short as possible;
- keeping waitlists as short as possible;
- encouraging and providing innovative new services;
- ensuring patient satisfaction; and
- making the changes needed to keep the province's public health care system affordable for the future.

The Better Teamwork, Better Care initiative shifted the focus of the ministry to the delivery of health care services and away from health and its broader determinants. The new initiative retained some of the elements of the New Directions

structure, but reduced the number of Regional Health Boards from 20 to 11 and Community Health Councils from 82 to 34. It also eliminated overlap in governance between the two levels. Under New Directions, community councils were to report to the regional boards—an approach that would, it was subsequently believed, create unnecessary duplication. As well, the new approach introduced seven Community Health Services Societies, which were made up of members from the community councils within a region.

The ministry also restructured itself in order to better support a regionalized health care system. Regional Programs is responsible for the funding and oversight of the health authorities. It carried out its work through seven Regional Teams and Tertiary and Provincial Services.

Current Service Delivery and Funding

At the time of the audit, the regional health care model was essentially unchanged from the structure of Better Teamwork, Better Care.

The boards, councils and societies shared responsibility for the delivery of different levels of health care services. The Regional Health Boards were responsible for acute care hospitals, continuing care facilities, and community health programs (public health, community home care nursing, community rehabilitation, case management, health services for community living, and adult mental health). Community Health Council responsibilities were focused on acute care hospitals, continuing care facilities and home support agencies. The Community Health Service Societies were responsible for providing community-based health services (public health, community home care nursing, community rehabilitation, case management, health services for community living, and adult mental health) to a number of communities within a geographic area.

All health authorities are allocated funds by the Ministry of Health so that they can provide health services to their specific communities. In turn the health authorities are expected to allocate their funds to programs and services in accordance with their ministry-approved health service plans.

Funds are generally allocated by the ministry on a program basis (such as for acute care), with some funds earmarked for specific ministry priorities such as continuing care renewal. Once allocated by the ministry, program funds are not to be moved across programs, with the exception that funds can be moved from acute care programs to other areas such as public

and preventive health and mental health. However, even here ministry approval is required before such a move. In 1999/2000, funding Regional Programs totalled $4.9 billion, 62% of the total health care budget. In 2001/02, the amount is estimated to be $6 billion.

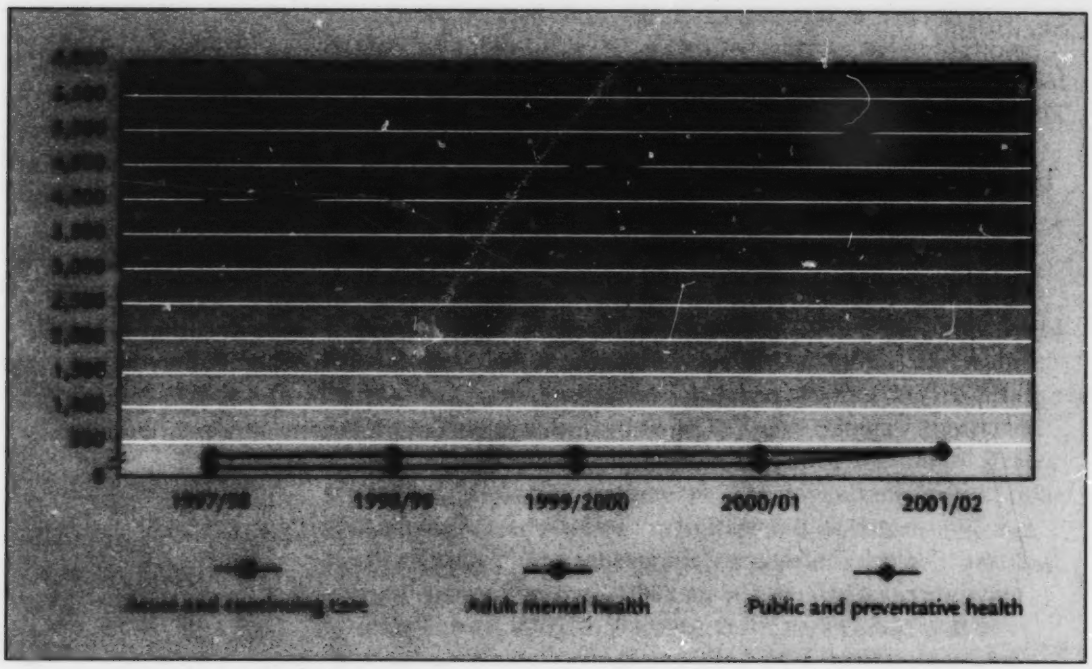
Exhibit 2 shows how funds have been allocated by program within regional programs for the period 1997/98 to 2001/02 (estimate).

With the election of a new government in May 2001, the Ministry of Health and Ministry Responsible for Seniors has been restructured and is now two ministries: the Ministry of Health Planning and the Ministry of Health Services. The latter has two Ministers of State, the Minister of State for Mental Health and the Minister of State for Intermediate, Long-term and Home Care. Regional Programs continues to carry out its work through seven Regional Teams and Tertiary and Provincial Services.

Exhibit 2

Regional Program Expenditures, 1997/98 to 2001/02*

$ Billions



Source: Office of the Auditor General for 1997/98 to 2000/01, *British Columbia Estimates for 2001/02 (change in Public and Preventive Health includes transfer from the former Ministry for Children and Families for health programs)

audit questions

In approaching this audit, we asked three fundamental questions about the resource allocation process:

1. Has the ministry set a clear direction for the regional health care system?
2. Has the ministry used information appropriately to support the regional health care system?
3. Is the ministry appropriately reporting on the performance of the regional health care system?

In the chapters that follow, we report on what our audit found with regard to these questions.

Question 1: Has the ministry set a clear direction for the regional health care system?

The health care system is both complex and expensive. As funder and steward of the system, it is important that the Ministry of Health provide clear direction. We looked to see if the ministry had done so.

Conclusion

The ministry has not set clear direction with measurable performance expectations for the regional health care system. The ministry has developed key guides that provide direction for the regional health care system. These include principles, a three-year strategic directions document, and an accountability framework that defines roles and responsibilities but not performance expectations. As well, the ministry has also developed other documents, which also provide direction to the health authorities. However, all of these documents have been developed independently of each other and so do not provide a cohesive framework—that is, one able to guide and support resource allocation decisions, strategic choices and trade-offs and performance reporting.

Findings

Guiding documents have evolved independently over time and do not provide a cohesive framework

In February 1998, the ministry outlined seven principles that health authorities were to follow in planning and managing health services. Such services, the ministry said, should:

- be developed, delivered and evaluated in collaboration with consumers and should respect the diversity of British Columbians (consumer focus);
- focus on decreasing the disparity in health status among population groups (equity);
- give all British Columbians access to the health services they require (access);
- be managed and delivered to provide the best possible outcomes for British Columbians (effectiveness);
- be managed and delivered at the lowest cost consistent with quality services (efficiency);
- provide the right service at the right time in the right place (appropriateness); and
- focus on minimizing risks to the health and safety of British Columbians (safety).

These seven principles are in line with the standards of the Canadian Council on Health Services Accreditation (CCHSA). However, the CCHSA also includes two additional standards: competence (an individual's knowledge and skills are appropriate to the care services being provided) and continuity (the ability to provide uninterrupted, coordinated service across programs, practitioners, organizations, and levels of care/services over time).

In 1998, the ministry also released its accountability framework for health authorities. This document outlined the roles and responsibilities of the health authorities and ministry, but did not provide clear performance or reporting expectations for the authorities. In the fall of 2000, the ministry contracted with a consulting group to develop an implementation strategy for the accountability framework. The consultants' report noted that accountability-related activities and initiatives had not taken place within a systematic corporate approach, and that several essential steps within an accountability cycle were absent. The ministry has accepted the report and will be developing plans for implementing its recommendations.

In the fall of 1999, the ministry issued its *Strategic Directions for British Columbia's Health Services System 1999–2002*. Strategic Directions sets out nine major goals, each with a number of objectives and sub-objectives (see Appendix B). That document, we found, is so broad in its reach that it does not offer effective guidance for decision-making. For example, we noted that the ministry did not make use of these nine goals to support or facilitate decisions about resource allocation. Furthermore, the ministry has not made the goals operational by developing indicators or targets that would allow it to monitor performance towards achievement of either the goals or desired outcomes over the period of the plan. (For 1999/2000, the ministry did develop a work plan, which specified deliverables for some sub-objectives, but staff did not check to see whether the deliverables were achieved, and no work plan was developed for the following year.)

Although the Strategic Directions document incorporates some of the planning principles into its goals and objectives, it omits two important ones—appropriateness and safety. Safety is mentioned in the context of health care workers, which is very important, but there is no mention of safety relative to patients. This omission is significant in light of recent studies from the United States and other jurisdictions about the incidence and extent of 'medical errors' and their impact on patients and the health system overall.

In addition, although health authorities are expected to align their health service plans with the ministry's Strategic Directions document, it does not set out any clear, measurable performance expectations related to specific ministry objectives.

In December 2000, the Health Action Plan was announced, providing additional funds to address a number of issues. This initiative captured some aspects of the ministry's strategic directions and provided for very specific outputs, for example 50 nurse refresher seats in January 2001 and 10 new medical radiologist seats in January 2001. However, it was not clear how the chosen priorities were selected or how these priorities meshed with the priorities established by the health authorities in their health service plans. When the Health Action Plan was launched the Health Minister also announced that a committee of independent health experts would be named to measure and report on the progress of implementation.

The message of the ministry's guiding documents is not clearly and consistently communicated

Because the ministry has developed its accountability framework, strategic directions, principles and priorities independently of each other, they are not used to support decision-making for resource allocation and are not precise enough to support clear performance expectations. In our view the documents are ambiguous and so broad that they can be interpreted to fit any situation. They do not connect operations with the strategic direction.

Health authority health service plans reflect the ministry's strategic directions

Health authorities are required to develop a strategic health service plan that specifies the major changes they would like to bring about in their health services. The ministry very broadly defines "major changes" as changes that are made to achieve improved health, sound fiscal management, and health reform that may affect consumer access, human resources, capital or funding.

The ministry planning guidelines direct health authorities to undertake service planning within the context of the ministry's strategic directions and giving consideration to:

- the provincial health goals;
- the ministry planning principles; and
- provincial strategic initiatives, such as those for mental health and continuing care renewal.

In addition to health service plans, the health authorities are expected to develop information management resource plans, capital plans, and plans to address provincial strategic initiatives. The major strategies of these individual plans are to be reflected in the health service plans.

The health service plans that we reviewed (we did not review the other plans) adequately reflected the ministry's strategic directions, health goals and planning principles. As well, most of the health service plans established goals and objectives specific to both mental health and continuing care.

Question 2: Has the ministry used information appropriately to support the regional health care system?

We expected that the ministry would use its resource allocation decisions to move the health care system in the strategic directions the ministry has set. In particular, we expected the ministry to have a model for resource allocation that was well supported by appropriate information about its goals and objectives and how well they are being achieved.

Conclusion

The ministry has not used information appropriately to support the regional health care system. Of most concern to us is that the ministry lacks an appropriate model for allocating resources to the regional health care system—that is, a model that is transparent, applicable to the entire annual budget for Regional Programs, and responsive to information relevant to the ministry's stated health care objectives.

Findings

Budget development relies on historical spending levels

When developing its annual budget, the ministry consults health authorities and other stakeholders, usually through a standing committee made up of health authority, ministry, union and association representatives.

The ministry uses historical spending levels to prepare its budgets. It takes the prior year's budget, makes adjustments for one-time expenditures and then works from those results. For example, when the ministry prepared its budget for 2001/02, it simply used its approved budget of $8.1 billion for 2000/01 as the starting point.

The same approach is taken in preparing the budgets of programs such as acute and continuing care, mental health and public and preventive health, which together account for over 60% of the overall health care budget.

The ministry's budget-building process consists primarily of identifying what additional funding will be added to the new budget. (For Regional Programs in the last three years, such funding has amounted to increases over each preceding year by about 8%.). For the 2001/02 fiscal year we found that ministry documents show that little consideration was given to expenditure reductions or revenue increases during the budget-building process.

A significant portion of additional funding each year is reserved for priorities that are set by government and communicated to the ministry through Treasury Board directives. Any spending increase must first go towards these priorities, which consist typically of wage commitments and the annualization of any expenditures approved during the previous year. Then come additional funds required to meet increases in prices, population and utilization of health care services, followed by funds required to pay for service enhancements and strategic initiatives.

The ministry prepares issue papers in support of each additional expenditure, reduction or revenue adjustment to the base budget. Issue papers are short one- to two-page documents that identify the program and division affected (e.g., Regional Programs, Tertiary Services), the type of issue (e.g., service enhancements), and the funding requirement and justification for it, and the effect of the proposed change.

To assess the type of information used in the budget-building process, we asked to review the issue papers and supporting working papers for the fiscal years 1999/2000 and 2000/01. The ministry was able to provide us only with limited information for those years. Therefore, we reviewed the documents for the 2001/02 budget. We found that the quality of the information provided in support of the budget submission varied. Most of the information in issue papers was general. Where data was included, it consisted mainly of estimated anticipated increases in utilization of services based on prior levels of utilization and changes in demographics. Data sources were only rarely referenced, and few impact statements were supported by sound analysis.

We also looked at detailed working papers prepared in support of issue papers. In general, few working papers could be provided to us, and those that were available did not show extensive analysis, projection of trends or discussion of options.

Funding is allocated to the health authorities on a program basis

Once the proposed health care budget is debated and approved by the Legislative Assembly, the funds are allocated for regional health care and to individual health authorities on a program basis. Funding for the acute care program is further segmented. It is allocated first to tertiary services, then to approved beds or programs, and finally to other programs (e.g., Canadian Blood Services and midwifery). One more segment is for discretionary dollars the ministry holds back

as a contingency. Any remaining funds for acute care are then allocated according to the Hospital Funding Allocation Model. This model is based on the size and characteristics of the population and has been used by the ministry since 1993 (with some refinements to address socio-economic status).

As for the ministry's annual budget development, the starting point for program allocations is the historical spending patterns and not information on need or direction. For example, although the ministry requires health authorities to submit health service plans, it does not use these plans to help it make resource allocation decisions. We found that, generally, new spending is allocated based on service volumes, not on information relevant to the ministry's principles and stated directions (with the exception of the principle of equal access to service).

When funding decisions are not timely, health authorities cannot manage with reasonable certainty

Once the ministry's budget is approved, the ministry sends each health authority an allocation letter telling it the total amount of funding it is to receive for the year. The health authority then has 45 days to provide its spending plan to the ministry for review and approval. Until this approval is received, the health authority must continue to operate and manage based on its previous year's spending and service levels. When the allocation letters are delayed (as occurred in 2000/01), the health authority can do little to change the established spending pattern for the year. This means its ability to introduce new approaches to service delivery or implement changes to meet any budget shortfall is limited.

Ad hoc funding requests and approvals frequently lack supporting information or rigorous analysis

Throughout the year, cost pressures in the health care system always arise. Once identified, they are placed on a list by the ministry for funding consideration. They can be identified by any of the programs within Regional Programs, or by the health authorities acting through their Regional Team representatives. When a health authority raises an issue, it is generally up to the regional team members to decide if the issue needs to be placed on the list. The cost pressures vary in the amount of money required to address a specific issue. For example, in one ministry program all costs were not included in an original request and so the program is short of funds and requires an additional $1,000,000. In another situation a miscalculation in bed changes at a facility created the need for an additional $590,000. In a third example, a health authority required $300,000 to replace some computers.

The issues on the list are reviewed on an ad hoc basis. The decision to address one cost pressure over another depends on a number of variables, including:

- the amount of funding available to resolve the issue either one time or ongoing (i.e., adding it to the base budget);
- the priority of the issue compared to others;
- the options and recommendations presented by ministry staff who reviewed the issue;
- the nature and urgency of the issue; and
- where it is a health authority issue, the financial health and management performance of the authority and the circumstances that led to the issue.

Money to fund the issues behind the cost pressures can come from a number of sources. The ministry holds back some funds from its annual budget to deal with emerging issues. It can also use the unspent funds of a new program late starting up, or access funds from other ministry operations. Finally, if it cannot find the funds within its current budget, the ministry can request additional funds from Treasury Board. This request for additional funds must be approved through either a special warrant or supplementary estimates.

As with the budget issue papers, our review of a sample of cost pressure issue papers was limited because of the lack of supporting documentation. We therefore could not determine what type of analysis the ministry actually undertakes before approving extra funds to address a particular issue.

The ministry is developing a funding methodology

In 1992, the Royal Commission on Health Care and Costs recommended that regional budgets be based on a weighted capitation formula (that is, with estimates based on X dollars per citizen of the health region). The commission also called for the formula to incorporate local service needs and a broad base of population health risk indicators.

It was not until 1996 that the Ministry of Health developed a population needs-based funding model. The aim of the model was to apportion the ministry's budget to regions according to variations in need based on population size, age, gender, demographics and the impact of social, economic and environmental factors on population health status. In addition, the model considered the costs of providing services to remote and sparsely populated areas. The model was never implemented.

Four years later, in May 2000, the Minister of Health instructed the ministry to again have a population needs-based funding model ready for consideration for use in fiscal 2001/02. This time, development of the funding allocation model has been on a sector basis, and to date has only been completed for the acute care and continuing care (both residential and community) sectors. The models for mental health and public preventive health have yet to be completed.

The new model accounts for population size, age distribution, gender, socio-economic status, inter-regional referral flows, and cost of care delivery. However, it is intended to be applied only to the funds for those services and programs that are common to all health authorities and linked to population size and composition.

The sector models developed to date have been tested. If the model were put into use, funding for all 18 health regions (combines Community Health Services Societies and Community Health Councils) would change. Some changes would be small, but others would be as much as nearly 10%. Both the ministry and the health authorities felt it was not reasonable to expect regions to adapt to this degree of change in one or two years, particularly when the change represented a reduction in funding. Therefore, implementation is to be phased in over a number of years, and may entail a "no-loss" approach—that is, health authorities facing a reduced share of funding would have their budgets frozen at the level of the previous year (or, at best, receive minimal increases for unavoidable costs or wage settlements). Given the ongoing demands for additional funds for the health care system, we believe the ministry should re-evaluate its phased approach to implementation.

Introduction of a funding model will help to make the process transparent and more understandable by the health authorities—attributes the current process lacks.

Ministry information sources are not organized to support decisions on resource allocation

The ministry's lack of clarity in its overall direction for the regional health system is, in our opinion, a root cause of its failure to make information-based allocation decisions. As we have already noted, without a clear, principle-based model for resource allocation, the ministry does not have information it needs to appropriately manage the regional health care system.

Ministry Data Resources to Support Regional Programs

The Ministry of Health has a number of systems that receive and store data related to the management and delivery of regional health services. These data sources generally fall into two categories: those that store information about clients and those that store financial and statistical information. The ones most relevant to the regional health care system include:

- Health Authority Management Information System
  –provides financial and statistical data
- Health Sector Compensation Information System
  –provides health sector employment data
- Continuing Care Information Management System
  –provides client-specific and some financial data
- Client Patient Information Management
  –provides mental health client-specific data
- Discharge Abstract Database (hospitals)
  –provides client-specific information

It is not that the ministry lacks access to useful data. The problem is that this data can only be organized into information that is useful for decision-making once the ministry has clarified its direction. To maximize the benefits of the data sources it has access to, the ministry needs to clearly define the information it requires to support both governance and resource allocation processes. Some of these systems have evolved over the years in response to program- or function-specific needs and requirements, and may not meet the ministry's current information needs.

The ministry's Information Management Resource Plan broadly defines the business drivers of the health care system: regionalized governance; a shift towards community-based care; and the need for improved accountability, efficiency, equity, access and quality. However, we found few indications that the ministry had defined specific information needs relative to these business drivers. An exception is the public and preventive health program, which is in the process of defining its core business lines and the information required to support them.

Once the ministry has been explicit about its information needs, the challenge will then be for the ministry to ensure it has the capacity to analyze and synthesize the data, in turn producing information that can be used to support decision-making and for performance reporting. For this reason, we

have concerns about a ministry initiative currently underway to create a "health data warehouse" by collecting data from existing information systems and maintaining it in a huge database. The goal is to take data from diverse sources inside and outside the ministry and produce comprehensive and reliable pictures of health, health care services, and health care management across British Columbia.

According to the ministry, such a system will greatly enhance the quality of decision-making by partners of the health care system. However, we found that it is not clear:

- what the intended uses of the data are;
- what the ministry's information needs are;
- whether the health data warehouse will be able to meet those information needs; and
- whether the new initiative duplicates an existing system at the University of British Columbia.

We believe that the ministry should review its plan for the health data warehouse and fully address these issues.

Also under development is the Operational and Administrative Support Information System, a "decision-support" system that links financial data with information from a hospital discharge database. Its purpose is to develop an integrated data set that will allow for the production of routine and ad hoc reports for monitoring health authorities. We were concerned to find that the focus of the project is to provide reports to the ministry only. At present there is no intention to share the reports with the health authorities.

We believe the ministry should reconsider this approach. By sharing the information with the health authorities it would allow them to assess their own performance, benchmark against others and take a continuous quality improvement approach to performance.

Question 3: Is the ministry appropriately reporting on the performance of the regional health care system?

As the steward of the health care system, the Ministry of Health has an obligation to measure the performance of the health care system. In particular, the ministry should know and report publicly on the state of the regional health care system—its ability to meet the needs of the population, its quality and its sustainability.

To fulfil its reporting obligations, the ministry must clearly outline the performance and reporting expectations it has of the health authorities, and then monitor to ensure that the health authorities are meeting those expectations. Timely acquisition of relevant, reliable information is key to determining whether the direction set is being followed, whether the health care system is achieving the intended results and desired outcomes, and whether resources are being allocated appropriately.

Conclusion

The ministry is not appropriately reporting on the performance of the regional health care system. Because it does not systematically monitor the health authorities' compliance with its reporting expectations, the ministry is limited in its ability to ensure it has accurate, relevant, timely information. Such information is critical both for resource allocation decision-making and for performance reporting. The ministry does report annually on the health status of British Columbians and on what health care services have been provided. However, this information lacks clear links to what the ministry intended to achieve through the provision of services.

Findings

The ministry does not provide a comprehensive picture of the overall performance of the regional health care system

The ministry currently reports publicly on the state of the health care system through:

- its annual report about health status, the provision of health care services and the performance of the health system as a whole; and
- its performance plans.

As well, the Provincial Health Officer reports annually on the health status of British Columbians and on progress in achieving the provincial health goals and improving the health of the population. However, he or she does not report on the overall performance of the health system.

Annual Report

Under the Ministry of Health Act, the Minister of Health must prepare an annual report of the work performed by the ministry. We first examined the ministry's 1999/2000 annual report, as it was one in which we expected to find that the ministry had reported on its achievements relative to its 1999 – 2002 strategic directions for the health services system.

The report focuses on four key areas of performance: overall health, accessibility, quality, and spending. For each of these, it provides trends over time, dollars spent and other general information. However, we found major weaknesses in the information presented.

- There is no clear relationship between the measures reported on and the ministry's stated direction.
- The choice of indicators does not appear to be linked to any clear expectations of performance.
- There is very little financial information included and no indication of what was achieved for the dollars spent.

For example, the report notes that $50 million in funding was announced to recruit and retain more nurses and that the government committed funding to hire 400 Registered Nurses in 1999/2000. Not explained in the report is how much of the $50 million was spent, or how many of the 400 nurses were hired.

In July 2000 the government enacted the Budget Transparency and Accountability Act, which calls for a focus on accountability for results, including comparing actual results for the preceding year with the expected results identified in that year's performance plan. (The Act was amended in August 2001).

Performance Plans and Reports

In April 2000, the ministry issued its performance plan for 2000/01 in anticipation of the enactment of the Budget Transparency and Accountability Act. We examined those sections of the ministry's 2000/2001 performance plan pertinent to the regional health care system. The introduction to the document states that the plan is a compilation of the major objectives of the ministry. Each objective is linked to one of the nine ministry goals stated in *Strategic Directions for British Columbia's Health Services System 1999–2002* and each has at least one performance measure established. However, we found the measures to be generally focused on outputs and activities rather than outcomes, and there generally were no targets or measures established.

In July 2001, the ministry released its 2000/2001 annual report, which included a section on its performance relative to its plan. While some activities and outputs were achieved, no explanation was provided for those that were not. It was not always clear that what the ministry reported was related to what it set as its measure. As well, the ministry sometimes

provided a specific measure of achievement, yet did not include what the starting point was. For example, the plan stated that the ministry would increase the number of hospitals reporting to the central transfusion registry. While the annual report states that 100 % of hospitals do now report to the central transfusion registry, the reader of this information has no idea whether the gain is from zero to 100% or 90 to 100%.

Other sections of the report, in our view, also had the same weaknesses as we identified for the 1999/2000 report.

The ministry's 2001–2004 performance plan, although still focused on outputs, does provide more baseline data and, in some cases, specific targets and measures. The ministry acknowledges in the document that the measures are still mostly related to outputs, and that the measures in the plan have been selected in part based on the ability of the health care system to provide reliable data within the time frame required in the Budget Transparency and Accountability Act.

Minister's Advisory Committee on the Health Action Plan Implementation

When the Health Action Plan (HAP) was launched, it was announced that a committee of independent health experts would be put in place to measure the progress of the plan's implementation and hold parts of the system accountable. According to the terms of reference, the committee was to:

- review progress reports on the implementation of the plan;
- assist in identifying and reporting on factors, that might impede or facilitate successful implementation of the plan;
- assist the Minister of Health in identifying problems and recommending solutions to problems associated with the plan's implementation;
- provide advice on health care expenditures; and
- report to the Minister on a regular basis.

The committee met three times between December 2000 and May 2001. Only its first report to the Minister was made public. Although the committee was to focus on the implementation of the Health Action Plan, in fact it reported on issues related to information management, resource allocation and openness. Included among its recommendations have been that the ministry should:

- fund the development of a data capture and management system that would allow the ministry to do a better job of monitoring outcomes from the health care delivery system;

- provide health authorities with better information about ministry decision-making processes to ensure transparency and accountability; and
- continue improving its ability to measure and evaluate Health Action Plan outcomes so that it can determine which initiatives are making a difference to the quality of health care in British Columbia.

Clearly, the committee believes that data collection, information management and performance reporting must be linked to the direction the ministry wants to go, and that resource allocation processes and decisions should move the system in the direction chosen.

Health authority performance expectations and reporting requirements are not clear and are not monitored systematically

As we have already discussed, the Ministry of Health establishes the direction for the regional health care system and then funds the health authorities to provide and manage the programs and services that will support the ministry's direction. Inherent in this arrangement is an accountability relationship: the ministry defines its expectations and the health authorities report against those expectations. Accordingly, we expected to find that the ministry had clearly defined performance expectations and reporting requirements for the health authorities, and had put in place a systematic process for monitoring compliance with its expectations.

Performance Expectations and Reporting Requirements

In the 1999/2000 Budget and Reporting Requirements provided to health authorities, the ministry outlined the authorities' financial and statistical reporting obligations, setting out both the data to be submitted and the frequency of the submissions. As well, the document explained that monitoring was to facilitate development of improved direct service provision and purchase service strategies for value for money (cost effectiveness), early identification of issues to be considered in the funding cycle, and distribution of health authority-specific comparative quantitative and qualitative analyses. Also, the ministry stated it wanted to:

- ensure policy requirements are met;
- identify potential risks and required actions;
- signal issues for policy development, funding methods and allocation;

- show comparative performance and create incentives for good performance;
- highlight good ideas that can be shared;
- demonstrate progress towards regionalization objectives; and
- inform the health authorities, providers, consumers and the community.

Health authorities are expected to report their financial and statistical data to the ministry on a "13 period basis," with each report to be delivered at the end of the following period (the first period report is due at the end of the second period, and so on). However, compliance with this reporting requirement has been problematic.

A committee of representatives from the ministry, health authorities, unions and associations has tabled an ongoing concern about reporting non-compliance, as well as about data quality. The committee has had some work done to assess compliance by health authorities. As well, in January 2001, an internal ministry committee was established to follow up on both compliance and data quality issues. Because this increased emphasis on compliance is recent, we were unable to evaluate the success of these initiatives, although there are several indications that compliance with reporting requirements is improving.

In our opinion, one reason given for poor compliance—doubts about whether the ministry made use of the data—has validity. We found very little evidence that the ministry uses what it collects to systematically monitor the health authorities, support the resource allocation process, provide feedback and comparative analysis to the health authorities, or ensure that the health authorities comply with the reporting requirements.

We found a similar problem with health service plans. Health authorities are required by legislation to develop and submit these plans, indicating how their programs and services will help achieve the ministry's strategic directions. These plans are seen by the Ministry of Health as a major accountability mechanism, yet we found no evidence that the ministry intends to integrate this information into the resource allocation process, the budget-building cycle, or any other function. It was also not clear whether a review of the achievements against the plan was given any consideration in the approval process for the subsequent plan.

As important a concern to us as compliance was also the question of who is actually responsible for monitoring health authority performance overall. Regional teams seem to have some responsibility, as do financial staff and joint committees, but it was unclear to us who is to take action if issues are identified.

Health Indicators

In January 2000, the Ministry of Health and the health authorities established the Performance Indicator Working Group. The mandate of the working group was to develop a set of provincial performance indicators for health authorities. Its criteria for choosing the indicators included availability of data, evidence of cause-and-effect, identification of short- and long-term impact and degree of influence of the health authorities. The group agreed on an initial 34 indicators, including 5 that are considered system characteristics rather than indicators of performance and 14 that are reported on in the Provincial Health Officer's annual report (see Appendix C for a complete listing). The working group did not include any financial indicators in its final selection.

In March 2001, the Ministry of Health issued for consultation a draft report entitled *Health Authority Performance Indicators Assessing the Performance of Our Health System*. The report is intended to provide high-level information to the public on how well each health authority is meeting the priority goals of health service delivery set out in the ministry's *Strategic Directions for British Columbia's Health Service System 1999–2002*. Covered in the report are the 34 indicators developed by the working group. The document notes that the committee had little choice but to report on what could be measured rather than what it wanted to measure. As well, the document notes that despite an appearance of far-reaching and widespread data collection, there is little consistent, reliable information available on many important aspects of the health system, such as the outcomes of care.

It was not clear to us how the ministry intends to use the performance indicators report and whether it intends to integrate the information into the budget-building and resource allocation process in the future.

Ministry feedback to the health authorities is weak

The financial and statistical data collected by the ministry is not collated, analyzed and then shared with the health authorities, and the health authorities cannot directly access Ministry of Health data sources to generate their own reports. However, the ministry is taking some steps to address the issue of data access by upgrading the Health Authority Management Information System so that it is web-based. This will allow the health authorities to access the same reports as the ministry does.

At one time, the ministry issued reports that allowed comparisons of hospitals in similar peer groups (similar size and patient mix). Although these reports had flaws (including, for example, data inaccuracy), they provided some comparative measures of hospitals and encouraged management to conduct further investigation in areas where there were significant variances. Health authorities believe that similar reports, at a health authority level or even at the level of individual hospitals, would be useful.

This lack of access to both information about their own performance and comparative information raises questions about the transparency of the system and how the ministry uses the information.

ministry response

Thank you for the opportunity to respond to your draft report, Information Use by The Ministry of Health in Resource Allocation Decisions for the Regional Health Care System. *I believe the report to be an accurate assessment of where we were at the time of the audit. However, as you may be aware, there have been and will continue to be significant changes within the Ministry of Health Services and Ministry of Health Planning which will address many of the issues raised in your draft report.*

Allocating health care dollars across the province in a fair, equitable, transparent and comprehensive manner is a challenge for our Ministry and every other health ministry across Canada. I would even say it is a challenge for every other social policy ministry across Canada. While we have a long way to go before we can link our investment in health care services with targeted patient health outcomes, we have developed a population needs-based funding method, which allocates funds based on the population's relative need for health care. We recognize this may not be the definitive approach to solving the resource allocation issues raised in your draft report, but we are taking steps to improve it. This fiscal year we will be implementing the model for all acute care funding.

Through the Core Services Review, our major strategic shifts and new core businesses have been developed to meet the New Era goals of providing high-quality patient- centred care, improving the health and wellness of British Columbians, and creating affordable and sustainable public health care. These goals and systemic changes are now reflected in the Ministries' 2002/03 to 2004/05 Service Plans. As outlined in our Service Plans, the Ministries of Health will be undertaking several major initiatives to improve financial accountability and create more cohesive linkages between its performance planning and that of the regions.

One of the most important changes already initiated in December, 2001, is the restructuring of the province's network of 52 health authorities to six, which will improve efficiency, strengthen accountability and allow better planning and service coordination for patients. The scattered, inequitable division of responsibilities for 52 health authorities made the system as a whole unaccountable. The Ministry has established clear roles and responsibilities with increased accountability resting with the health authorities, to identify regional health needs and plan appropriate programs and services; and ensure that programs and services are properly funded and managed. Five geographical health authorities instead of 52, allow the Ministry to allocate resources in a more equitable manner and for the health authorities to then reallocate funds across their region as required.

This change sets the foundation for improved accountability between the health authorities, Ministries of Health, government and the public. The Ministry can now focus on: the development of provincial goals and province-wide standards; holding health authorities accountable for fulfilling their responsibilities; and ensuring appropriate health outcomes are achieved province-wide.

To match the changes within the health authorities and to improve the monitoring and evaluation role of the Ministry of Health Services, we have established new business units within the new division, Performance Management and Improvement, with responsibility to develop standards, performance expectations, and performance management processes. A key project of our new division is the implementation of performance management agreements with health authorities, articulating expectations and accountabilities to ensure the public obtain good value, services and improved health outcomes for the health system.

Our new division, Corporate Services and Financial Accountability, has taken on the task of improving the financial accountability of the health authorities. As the Ministry's financial planning is based on a three-year budget target, we will provide the health authorities with a detailed budget planning scenario and set of assumptions for the period 2002/03 to 2004/05, after the budget speech in February, 2002. Based on their three-year budget targets, health authorities will be expected to submit budgets based on the planning principles provided for them. The Ministry will monitor health authority financial performance on a monthly basis and implement a response plan to deal with non-performing organizations. To support clear direction and lines of communication between the Ministry and health authorities, financial expectations and outcomes will also be outlined in the performance management agreements.

Clear communication, including the exchange of financial and statistical information between the health authorities and the Ministries is an important component of the Ministry's resource allocation decision processes. The Ministries of Health are paying closer attention to the quality and timeliness of information reported by the health authorities. In the past year, reporting processes and data quality was noted by an internal audit conducted by the Office of the Comptroller General (OCG). The OCG's Report on Health Authorities Financial Reporting Processes *recommended specific changes to improve the relevance, consistency and timeliness of the financial and related statistical reporting provided by health authorities to the Ministry of Health Services, as well as the management of this information. The Ministry of Health Services has implemented many of the recommendations and is continuing to work with health authorities to address reporting issues.*

As the Ministries of Health are working to improve its resource allocation decision processes, I would offer the following response to your draft report's key findings:

Key Finding 1: The ministry provides direction to the regional health care system through various written documents, but there is no cohesive framework of clear measurable performance expectations.

- *Upon restructuring of the health authorities in December, 2001, the Minister of Health Services provided the six new Board Chairs with a letter of expectation which laid the foundation for governance, financial and service delivery expectations. These expectations fit with government's New Era for British Columbia and the Ministries of Health's Service Plans, to be released with the budget speech in February, 2002.*
- *We are preparing performance management agreements between the Ministries of Health and Health Authorities. These contracts will be a significant facet of the government accountability framework —consistent with government strategy, and Ministries of Health strategic priorities and service plans. The agreements will contain performance expectations, performance measures, reporting requirements and incentives/penalties. The first agreement will be in place for the 2002/03 fiscal year.*
- *The performance management agreements will contain three categories of deliverables: 1) "must do's" which are essential performance requirements, 2) "should do's" which are other priority system performance improvements, and 3) "could do's" which are other health activities that the health authorities are involved in, but for which we do not stipulate targets or benchmarks. For example, as an essential requirement (category one), health authorities will develop and deliver to the Ministry of Health Services a comprehensive budget and expenditure/revenue plan. Also in category one is the requirement that health authorities provide comprehensive, accurate and timely financial and statistical reporting.*
- *We are improving the linkages between the Ministries' budget development, Ministries' Service Plans, Health Authority Performance Management Agreements, Health Authority Service Plans, and Ministries' Performance Reports.*

Key Finding 2: Budget development and resource allocation processes and decisions are not supported by appropriate information or rigorous analysis.

- *The Ministries of Health budget development for 2002/03 to 2004/05 has been linked with the Core Services Review and New Era priorities. Currently, the Ministry uses financial and statistical data*

submitted by health authorities in its analysis of potential budget strategies. Once performance management agreements are in place the Ministry will monitor health authority performance according to the agreements and use related data/results to inform the Ministries of Health's budget development for subsequent years.

- *We are moving away from targeted regional funding to allocating global funding through a population needs-based funding (PNBF) model. Implementation of the PNBF model will occur in 2002/03, as committed by the Minister of Health Services at the December 12, 2001, open Cabinet meeting. Further comments on PNBF are provided under "Key Finding Three."*
- *At the end of 2000/01, the Ministry created a new process for reviewing, analyzing and approving mid-year funding requests from the health regions and other funded agencies. This process requires the regional and financial consultants to prepare an analysis of the funding request using the new form, Application for Operating Funds. This form structures the analysis and information required by decision-maker(s) in order to improve funding decisions.*

Key Finding 3: The ministry is developing a population needs-based funding model.

- *The Ministry's PNBF model incorporates methodology which account for: population demographics, socioeconomic status, gender, rural-remote geography, aboriginal populations, complexity of services and finally for investment in teaching and training of health professionals. The model has been extensively reviewed by the health sector, health planners across the country and a number of academics.*

Key Finding 4: Reporting by the ministry does not provide a complete picture of the performance of the regional health care system.

- *We are working to improve our performance plans and performance reports as required by the Budget Transparency and Accountability Act. The Auditor General's recent report, Building Better Reports: Public Performance Reporting Practices in British Columbia, lists the Ministry of Health's 2001/02 to 2003/04 performance plan and 2000/01 annual report as being one of the better examples. Future Ministries of Health Performance Plans/Reports will provide financial and statistical performance measures and results of the regional health care system. Outcome measures in the Health Authority Performance Management Agreements will roll up to the provincial level.*
- *The Ministry of Health Services is developing an information management strategy, focusing on health information for the general population and on data standards for regional health authorities.*

Key Finding 5: Ministry monitoring of the health authorities should be improved.

- *The Ministries of Health have been restructured to reflect the new structure of the health authorities. The new Performance Management and Improvement Division (PMID) will monitor the performance of health authorities based on the requirements of the performance agreements and Ministry policy and guidelines.*
- *In 2000/01, the Ministry established the Committee of Health Authority Monitoring of Performance (CHAMP) to develop strategies and solutions to health authority reporting issues. An escalation process has been established to address health authorities that do not comply with reporting policies: 1) the financial consultant contacts the health authority financial/reporting contact to discuss the reporting issue; 2) the financial consultant and PMID manager jointly contact the health authority Chief Financial Officer; and 3) a letter is sent from the Associate Deputy Minister, PMID to the Health Authority Chief Executive Officer, outlining the Ministry's concerns. As a result reporting compliance has improved.*
- *We have recently released the Health Authority Management Information System online, called eHAMIS. Health Authorities can now review other health authorities financial and statistical data to make comparisons and address their own data quality issues. Already this has led to greater consistency and timeliness of reporting. In fact, until health authorities are able to fully consolidate under the new structure, they are using eHAMIS as the tool to roll up information gathered under the old health authority structure. Comprehensive, accurate and timely reporting will also be one of the essential elements of the performance management agreements.*

I have attached a preliminary action plan, which states some of the ongoing and planned actions we are taking to address your draft report's recommendations. As we are in the process of making changes to the way we do business, I would appreciate your feedback on this action plan.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
1. Direction & Expectations			
The Ministry should:-			
▪ Define its information needs	Corporate Services & Financial Accountability: Information Support	▪ Provide information for lead program areas for service plans for both Ministries. ▪ Defining data requirements for Community and Home Care (formerly Continuing Care) and Mental Health. ▪ Participating in Ministry working groups to 1) implement a minimum data set for mental health and 2) develop a minimum data set for Community and Home Care. ▪ Define and refine financial and statistical MIS information at the organizational level.	▪ Link with the Performance Management & Improvement, Standards & Performance Development Branch. ▪ Further refine information requirements, e.g., workload, finance. ▪ Develop policy for reporting requirements on organizational, financial and statistical data including sub-sectors. ▪ Distribute MIS policy requirements to health authorities for reporting in fiscal 2002/03.
	Performance Management & Improvement Division	▪ Prepare Performance Management Agreements for April 1, 2002. ▪ Work with Information Support and industry committees to define and refine financial and statistical information requirements at the organizational level.	▪ Define and test minimum data set for all service sectors, provincial programs, strategic initiatives. ▪ Establish performance expectations and deliverables based on data sets, which link to the Ministries' Performance Plans.
▪ Set measurable performance expectations that support the ministry's strategic direction, and governance and resource allocation decisions.	Corporate Services & Financial Accountability: Information Support	▪ Provide data and ad hoc analyses to program areas. ▪ Provide information to program areas about data availability and reporting compliance. ▪ Support financial and statistical requirements for various reports, e.g., funding formula, MOHS/P Health Service Plans, Annual Report.	▪ Review performance measures for MOHS/P Service Plans to support data requirements within the scope of Information Support. ▪ Enhance existing indicator report (HAMIR) to reflect new governance structures and develop new indicator reports for other priority areas. ▪ Improve information to support strategic directions and resource allocations.
	Performance Management & Improvement Division	▪ Develop Performance Management Agreements which contain performance objectives, expectations and measures which link to the Ministries Performance Plan and strategic direction. ▪ Establish incentives to improve performance outcomes.	▪ Negotiate Performance Management Agreements on an annual basis to ensure that strategic shifts, new standards, targets and expectations are accommodated. ▪ Monitor performance and administer performance incentives as required.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
1. Direction & Expectations (continued)			
▪ Develop and publish an accountability framework for the regional health care system that describes roles, responsibilities and performance reporting expectations	Corporate Services & Financial Accountability: Information Support	▪ Set policies around timelines, format and quality of data, e.g., HARP feedback, data checking for validity, error reports, fill in data gaps retrospectively.	▪ Develop comprehensive compliance report for health authorities for all organizational and person specific reporting (DAD, HAMIS, CCIMS, CPIM).
	Performance Management & Improvement Division	▪ Develop Performance Management Agreements, which outline the roles/responsibilities and Ministry's expectations, including performance reporting expectations. ▪ Due to restructuring of health authorities there is a clearer understanding of roles, responsibilities and governance structure of the regional health system.	▪ Ensure all new provincial and strategic initiatives are integrated into the accountability framework. ▪ Enhance performance measures to include new data reporting expectations as required.
▪ Issue health authority funding allocation letters prior to the beginning of the fiscal year	Corporate Services & Financial Accountability: Information Support	▪ Support data requirements ▪ Define financial and statistical reporting requirements for budget letter and submission	
	Corporate Services & Financial Accountability: Finance & Decision Support	▪ With the budget speech scheduled for Feburary 19, 2002, the Ministry is on track to provide health authorities with their 2002/03 funding allocation as well as planning assumptions for 2003/04 and 2004/05, prior to April 1, 2002.	▪ In subsequent years, with the implementation of the PNBF formula allocating all regional grants, the Ministry will be able to provide health authorities with an updated funding allocation upon release of the government's budget. ▪ Working toward a "single" and consolidated funding letter to the health authorities from all areas of the Ministries.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
1. Direction & Expectations (continued)			
▪ Ensure that reporting is connected to the authorities' accountability	Corporate Services & Financial Accountability: Information Support	▪ Health authorities are currently required to submit financial and statistical data to the Ministry on a monthly basis. Data requirements based on CIHI's Management Information System Guidelines. ▪ Committee for Health Authority Monitoring of Performance (CHAMP) was established to review and monitor performance and reporting. ▪ Committee on Program Reporting (COPR) was established to review and monitor person-based records reporting.	▪ Review membership and terms of reference of CHAMP to reflect new regionalized governance structure and new ministry organization.
	Performance Management & Improvement Division	▪ Provides project leadership for CHAMP. ▪ Currently developing Performance Management Agreements which will require health authorities to submit performance data that links to the Ministry's Performance Plans/Reports.	▪ Redefine the role of CHAMP and establish appropriate membership and activities to ensure that established minimum data set is consistent with health authority accountability framework. ▪ Develop and implement a response plan to deal with non-performing organizations. ▪ Ensure that health authorities provide the information and data required to improve the Ministry's ability to monitor and evaluate performance and outcomes. ▪ Ensure that health authorities' Service Plans link to the Performance Management Agreements and the Ministries' Service Plans.
2. Use of Information			
The Ministry should: ▪ Use information relative to goals and objectives and health system performance in developing its budget.	Corporate Services & Financial Accountability: Information Support	▪ Provide data and indicators for evaluation, assessment and analysis. ▪ Provide support for population needs based funding.	▪ To support Performance Management & Improvement, Standards & Performance Development Branch (performance contracts) ▪ Enhance and develop more indicators.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
2. Use of Information (continued)			
	Corporate Services & Financial Accountability: Finance & Decision Support Performance Management & Improvement Division	▪ The Ministry develops its budget for regional grants using information on population/ demographic growth and general inflation increases by sector of the health care system, i.e. acute and continuing care. It also includes government's strategic priorities for programs and changes in service delivery, i.e. the Mental Health Plan. ▪ As the Ministry's budget target is set with zero growth over the next 3 years, the 2002/03 budget for regional grants was based on health authority expenditure information from 2001/02 (projections) and 2000/01 (actuals) to estimate the total reductions required to compensate for projected growth.	▪ Provide advice from industry and other experts on new performance indicators that express the Ministry's goals and objectives. ▪ Health authorities will be required to fulfill government's strategic shifts in service delivery by managing within their current base funding allocations. Basically, the total regional grants funding will remain stable while health authorities address growth due to population, inflation and wage increases internally. ▪ Funding allocations for all sectors except for provincial programs (targeted to the Provincial Health Services Authority) will be eventually based on the PNBF model.
▪ Develop an approach to information management that supports continuous quality improvement in performance of its governance and stewardship of the health care system.	Corporate Services & Financial Accountability: Information Support	▪ Support quality improvement through timely provision of data and widespread access including e-HAMIS, PURRFECT, population statistics. ▪ Promote data sharing, e.g., health authorities can view data from other health authorities.	▪ Improve e-HAMIS reports. ▪ PURRFECT will be restructured to provide data reflecting new regionalized governance structure. ▪ Coordinate training sessions with users of reports and data. ▪ Establish regular standard reports ▪ Design standard reports in response to ad hoc requests. ▪ Develop Executive Management Report. ▪ Develop a new health authority Data Sharing Agreement with IMG to facilitate more efficient data sharing between health authorities and the MOHS/P.
	Performance Management & Improvement Division	▪ Work with the health authorities to meet objective of quality improvements and account coding consistency.	▪ Work with health authorities on comparative analysis to meet goals of account code consistency and efficiency regression.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
2. Use of Information (continued)			
	Corporate Services & Financial Accountability: Information Management Group	▪ Improve quality through rigorous application of project management methodologies, data quality tools and improved quality assurance processes. ▪ Improve data linkage and integration to enable comprehensive analysis of health data through the data warehouse initiative. ▪ Give priority to projects that enable performance monitoring and reporting.	▪ Collaborate with the Health Authorities to improve data collection and reporting mechanisms for performance measurement and accountability. ▪ Continue to establish IMG as a cross government center of excellence for Project Management.
▪ Assess its capacity to use information.	Corporate Services & Financial Accountability: Information Support	▪ Promote education of ministry staff (determined lack of knowledge of health information and analysis capabilities). ▪ Provide training sessions to program area staff. ▪ Provide reports, e.g., Health Authority Profiles. ▪ Presentations to industry, e.g., HAMIS, web access to frequently asked questions, Chart of Accounts online.	▪ Regular meeting with ministry and health authorities staff to ensure proper submission and use of data/reports. ▪ Determine and allocate CIHI training for industry and ministry staff. ▪ Explore other tools that help us better understand the health system, e.g., Quantum Analyzer. ▪ Exploit power of GIS software to display health statistics and analyses.
	Performance Management & Improvement Division		▪ Assess need of new staff members for training in information systems and management. ▪ Complete work sessions on data sets, analysis of and relation to goals and objectives within the accountability framework.
▪ Ensure that the health data warehouse will meet its information needs.	Corporate Services & Financial Accountability: Information Management Group	▪ Business requirements analysis is an integrated part of the project deliverables. ▪ On-going participation of stake-holders ensures that the data ware-house meets the business needs. ▪ Results from the pilot uses of the data warehouse indicated that the system adequately addressed the business needs. ▪ The data warehouse offers linkage and integration of data from the health sector to enable better utilization of data.	▪ Phase II of the project will integrate insurance data, financial data and depersonalized client based data to allow more streamlined usage. ▪ The data warehouse has a built-in capability to accommodate future information needs, e.g., surveillance data.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
2. Use of Information (continued)			
▪ Ensure that the proposed data warehouse does not duplicate an existing UBC system.	Corporate Services & Financial Accountability: Information Management Group	▪ UBC has been a stakeholder of the project since project initiation. ▪ The data warehouse will be able to provide more comprehensive and higher quality data to UBC for its research purposes. ▪ Although some degree of data overlapping exists, the two systems significantly differ in purpose, usage, data scope and volume, and technical approaches. ▪ In addition to being a data warehouse utility, the Ministries' system is also designed to replace a failing operational system.	▪ Continued involvement of UBC and other stakeholders in the warehouse project.
▪ Develop the information systems capacity to provide the data to measure performance	Corporate Services & Financial Accountability: Information Support	▪ Develop data quality tools. ▪ Utilize technical resources of IMG to build systems to maximize meeting data requirements.	▪ Develop Executive Management Report. ▪ Develop greater on-line capacity to provide data and information more timely and efficiently.
	Corporate Services & Financial Accountability: Information Management Group	▪ The data warehouse has the capacity and flexibility to address performance measurements issues. ▪ The Ministries have the technical expertise to address performance measurement needs, as defined by the business areas.	▪ The data warehouse has the tools to put the data analysis and reporting functions on the desk tops of managers, planners and governors thus reducing the reliance on technical and research staff.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
3. Resource Allocation Model			
The Ministry should: ▪ Implement a resource allocation model that is transparent, understandable, and that links information about performance to resources allocation decisions and choices.	Corporate Services & Financial Accountability: Information Support	▪ Support and develop the Population Needs Based Funding (PNBF) formulas to allocate funds for the acute and continuing care sectors. ▪ Model uses population/ demographic and socio-economic status information to determine the health care needs of the five geographic regions of the province. Funds are allocated based on the resource intensity weights of various programs and procedures. Health authorities have been consulted during the development of the model, which is considered to be a fair, equitable and transparent funding allocation methodology. Reduced number of health authorities improves the model's ability to distribute funds in a fair and equitable manner.	▪ Continue to refine and enhance PNBF model (funding formula and allocation methodology) and data support models to include the adult mental health and public/preventive health sectors.
	Performance Management & Improvement Division	▪ Provide advice on health authority needs for flexibility with funding allocation decisions and expenditure policies. ▪ Provide advice on targeted funding, primarily with allocations to the Provincial Health Services Authority.	▪ Refine definition of tertiary/ provincial programs in order to determine the Ministry's approach to targeted funding for the Provincial Health Services Authority (PHSA).
	Corporate Services & Financial Accountability: Finance & Decision Support	▪ Works with Information Support to develop and refine the parameters of the PNBF model. ▪ Used the PNBF formula for the acute care sector to allocate equipment and population/ demographics funding to health authorities in 2001/02.	▪ Implementation of the PNBF model will be phased in beginning in 2002/03 to allocate the acute care, continuing care residential and continuing care community funding to health authorities.

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
3. Resource Allocation Model (continued)			
▪ Introduce the budget reallocations based on the model on a more timely basis.	Corporate Services & Financial Accountability: Finance & Decision Support	▪ The Ministry will provide health authorities with a detailed budget planning scenario and set of assumptions for the period 2002/03 to 2004/05, prior to April 1, 2002.	▪ Health authorities will receive their funding allocation for 2002/03 with their Performance Management Agreements prior to April 1, 2002. The PNBF formulas will be used to allocate a portion of the acute and continuing care funding. ▪ The Ministry will only send Funding Letter Updates to health authorities when/if funding levels are altered.
4. Accountability Reporting			
The Ministry should: ▪ Provide health authorities with reports on their performance and give them direct access to the information so that the health authorities can assess, monitor and compare their own performance to that of other health authorities.	Corporate Services & Financial Accountability: Information Support	▪ Provide data and reports, e.g., e-HAMIS, Health Authority Management Indicators Report (HAMIR), CCIMS, PURRFECT, Health Authority Profiles. ▪ Provide input into development of Health Data Warehouse.	▪ Enhance e-HAMIS reports. ▪ Allow wider access to e-HAMIS. ▪ Allow downloading capabilities of e-HAMIS for users to perform analysis. ▪ Enhance indicator reports including HAMIR. ▪ Allow health authorities to have more flexibility in the generation of mental health production reports. ▪ Create health authority/ministry user group to provide direction for enhanced e-HAMIS information dissemination. ▪ Develop greater on-line capacity to provide data and information more timely and efficiently.
	Performance Management & Improvement Division	▪ Work with Information Support and CHAMP to monitor health authority reporting compliance. ▪ Discuss and resolve reporting issues with health authority Chief Executive Officers when required.	▪ Work with Information Support to refine on-line reports. ▪ Work with Information Support to enhance reporting for provincial programs (PHSA).
▪ Ensure that reports and information on health authority performance are available and accessible to the public.	Corporate Services & Financial Accountability: Information Support	▪ Provide information for various initiatives, e.g., Annual Report, Health Authority Performance Indicators Report.	▪ Produce annual report on organizational performance using financial and statistical analysis (3-yr analysis). ▪ Publish various reports related to health authority performance (e.g., single item trend reports on daycare or a surgical procedure).

Recommendation	Area of Responsibility	Ongoing Actions	Planned Actions or Enhancements
4. Accountability Reporting (continued)			
	Performance Management & Improvement Division	• As noted above.	• As noted above.
• Report on the aggregate performance of the system and the authorities, providing comparative and contextual information that will allow British Columbians to assess the cost-effectiveness of health care services.	Corporate Services & Financial Accountability; Information Support	• Transfer B.C. data to national organizations for national reporting, e.g., re. Ability data to CIHI/StatsCan, Canada Health Act reporting to federal government.	• Able to provide information at request of any program area in consultation with the Standards and Performance Development Branch (Information Support may not have all data and B.C. may not use data definitions consistent with rest of Canada to assess cost-effectiveness).
	Performance Management & Improvement Division		• Provide analysis using industry and other health care experts appropriately. • Provide more meaningful data and information, which relate to the Ministry's goals and objectives and need to renew public trust.
	Corporate Services & Financial Accountability; Finance & Decision Support		• Work with Treasury Board Staff and OCG staff on the future consolidation of health authority financial statements with the Province's Public Accounts.

Glossary of Acronyms
DAD – Discharge Abstract Database
CCIMS – Continuing Care Information Management System
CHAMP – Committee for Health Authority Monitoring of Performance
CIHI – Canadian Institute for Health Information
COPR – Committee on Program Reporting
CPIM – Client/Patient Information Management System
FAQs – Frequently Asked Questions
GIS – Geographic Information Systems
HAMIR – Health Authority Management Indicators Report
HAMIS – Health Authority Management Information System
e-HAMIS – web-based Health Authority Management Information System
HARP – Health Authority Reporting Program
IMG – Information Management Group
MOHS/P – Ministry of Health Services/Planning
PNBF – Population Needs-based Funding
PURRFECT – Population Utilization Rates and Referrals for Easy Comparative Tables

appendices

appendix a

Health Goals for British Columbia

Goal 1: Positive and supportive living and working conditions in all our communities

The most important influences on our health are the working conditions we experience in our day-to-day lives. Meaningful work, healthy and supportive workplaces, sufficient income, safe and well designed communities, supportive families and participation in social networks significantly enhance our health.

Goal 2: Opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health

Our personal coping skills, sense of identity and effectiveness, control over life circumstances, commitment to life-long learning and the lifestyle choices we make are key influences on our health. These personal capacities and skills are shaped during early childhood, further influenced by our day-to-day living and working conditions, and affect our resistance to disease at a biological level.

Goal 3: A diverse and sustainable physical environment with clean, healthy and safe air, water and land

Sustaining a healthy environment is essential to our long-term physical survival and to our sustained social and economic well-being. As well, contamination of the physical environment can pose immediate threats to human health. Our challenge is to balance protection of the physical environment with the need for sustained economic activity while protecting human health and respecting the interests of individuals and communities.

Goal 4: An effective and efficient health services system that provides equitable access to appropriate services

Quality health services, when we need them, make an essential contribution to our health and well-being. At the same time, unnecessary or ineffective health care can harm our health and use up public resources that could be better spent elsewhere to enhance health. Our challenge is to ensure we have an effective system that balances public and health care provider expectations, available resources and evidence regarding outcomes of service provided.

Goal 5: Improved health for Aboriginal peoples

Aboriginal peoples experience very significant health status inequities that have occurred as part of the historical legacy of our province and country. This goal highlights the need for action to reduce these inequities, including changes to ensure greater self-determination for Aboriginal communities.

Goal 6: Reduction of preventable illness, injuries, disabilities and premature deaths

A considerable number of major health problems can be prevented through specific targeted interventions. This goal identifies achievable and measurable reductions in health problems that take a significant toll on the health of British Columbians, and for which effective prevention or early intervention strategies are available.

Source: Health Goals for British Columbia, Ministry of Health and Ministry Responsible for Seniors, December 1997.

appendix b

Goals and Objectives Excerpted from Strategic Directions for British Columbia's Health Services System, 1999-2002

Goal 1:	British Columbians will continue to enjoy the best health status in Canada, and the status will continue to improve.
Objective 1.1:	To reduce the incidence of specific preventable diseases and deaths.
Objective 1.2:	To assist individuals, practitioners, and health authorities in planning for and responding to emerging diseases and changes in disease patterns.
Objective 1.3:	To reduce inequalities in health status among people in British Columbia—especially aboriginal people and those in geographic regions with lower health status than the average population.
Objective 1.4:	Use the provincial health goals to stimulate social, environmental, and economic actions to improve health in the broadest sense.
Goal 2:	British Columbians will have access to health care services within an acceptable time period.
Objective 2.1:	To develop, or reaffirm where now available, guidelines (i.e., minimally acceptable thresholds) for major areas of health services, from preventive and primary care through to acute and continuing care.
Goal 3:	British Columbians will have access to health care services within specified geographic distances.
Objective 3.1:	To develop, or reaffirm where now available, geographic access guidelines (i.e., minimally acceptable thresholds) for communities throughout the province.

Goal 4:	British Columbia will have an adequate supply of health care services.
Objective 4.1:	To ensure the supply of health care practitioners will be adequate and distributed equitably throughout the province.
Objective: 4.2:	To ensure that the quantity and distribution of capital resources, including facilities and equipment, is appropriate.
Goal 5:	The health service system will be organized and managed to ensure the sustainability of Medicare so all parts of the system can provide excellent care in return for the public's investment.
Objective 5.1:	To distribute resources appropriately to all areas of the province.
Objective 5.2:	To satisfy the public that health care services are receiving sufficient funding, and that the public is receiving good value for these resources.
Objective 5.3:	To support an information infrastructure that meets the needs of the evolving regionalized health service system, and the ministry's role within that system.
Objective 5.4:	To improve public understanding of how the health services system works, what it costs and how to use it judiciously.
Goal 6:	The health services system will provide consistently high quality health services that improve health and health outcomes, and satisfy British Columbians' expectations.
Objective 6.1:	To provide services which improve health and health care outcomes.
Objective 6.2:	To satisfy the needs and expectations of patients and clients.
Objective 6.3:	To ensure that the self-regulated professions fulfill their obligations to maintain professional standards of performance.
Objective 6.4:	To encourage the development of an integrated and comprehensive continuum of care.

Goal 7:	The regionalized system will be accountable to the Minister of Health, with health authorities operating according to plans approved by the ministry and within resources allocated to them.
Objective 7.1:	To maintain an effective governance process for health authorities.
Objective 7.2:	To promote and support a strong planning approach by health authorities.
Objective 7.3:	To establish effective partnerships between health authorities and physicians.
Goal 8:	Programs delivered directly by the ministry will be well managed.
Objective 8.1:	To strengthen accountability mechanisms for ministry programs.
Goal 9:	The working environment within British Columbia's health services system will be informed by a client-centred focus and characterized by a spirit of cooperation and excellence.
Objective 9.1:	To ensure that respective roles and responsibilities evolve within a framework of continuous improvement, and providers have clear direction on how to work as a team to deliver high quality health care services.
Objective 9.2:	To promote an environment of mutual respect among providers, support staff and patients.
Objective 9.3:	To ensure a safe physical environment in the health services system where all who work in the environment are knowledgeable about protecting their own health and safety and contributing to a safe work place.

appendix c

Health Authority Performance Indicators

1. Immunization rates for 2 year olds and school entry children
2. Influenza immunization rate age 65 years and over
3. Influenza immunization rate for residential clients
4. Rate of pertussis
5. Pneumonia and influenza hospitalization rate
6. Age specific smoking rates (age 12-18)
7. Number of confirmed falls in licensed adult day care facility
8. HIV infection rates (new cases)
9. Number of cases of campylobacteriosis, cryptosporidiosis and giardiasis
10. Percentage of waterworks systems/food premises with high hazard rating
11. Follow-up after hospitalization for persons with a mental health diagnosis
12. Residential beds per 1,000 population for 75-84 years and 85+
13. Paid hours per 1,000 population for home support
14. Visits per 1,000 population for direct care (home care)
15. Days per 1,000 population for adult day care
16. Acute weighted case per 1,000 population
17. Median wait times for elective hip and knee replacement surgery
18. Percentage of licensed facilities/food premises/water inspected annually
19. Percentage of referrals out
20. Percentage of referrals in
21. Percentage of total surgical cases which are surgical day cases
22. Expected compared with actual length of stay
23. Alternate level of care days
24. Hospitalization rate of ambulatory care sensitive conditions
25. May not require hospitalization
26. Readmission rates for mental health within 30 days of separation
27. Infant mortality rates
28. Low birth weight rates
29. Potential years of life lost and age standardized mortality rates
30. Influenza immunizations for staff in residential care
31. Confirmed reportable incidents in licensed facilities
32. Number of accepted Workers' Compensation Board (WCB) claims
33. Days lost due to accepted WCB claims
34. Costs of accepted WCB claims

Source: Ministry of Health, *Health Authority Performance Indicators, Assessing the Performance of Our Health System*, March 2001

appendix d

Office of the Auditor General: 2001/02 Reports Issued to Date

Report 1

Managing Interface Fire Risks

Report 2

Transportation in Greater Vancouver:
A Review of Agreements Between the Province
and Translink, and of Translink's Governance Structure

Report 3

Building Better Reports:
Public Performance Reporting Practices
in British Columbia

Report 4

Monitoring the Government's Finances

Report 5

Management of the Information Technology Portfolio
in the Ministry of Attorney General

appendix e:

Office of the Auditor General: Performance Auditing Objectives and Methodology

Audit work performed by the Office of the Auditor General falls into three broad categories:

- Financial auditing;
- Performance auditing; and
- Conduct of business auditing.

Each of these categories has certain objectives that are expected to be achieved, and each employs a particular methodology to reach those objectives. The following is a brief outline of the objectives and methodology applied by the Office for performance auditing.

Performance Auditing

What are Performance Audits?

Performance audits (also known as value-for-money audits) examine whether money is being spent wisely by government —whether value is received for the money spent. Specifically, they look at the organizational and program elements of government performance, whether government is achieving something that needs doing at a reasonable cost, and consider whether government managers are:

- making the best use of public funds; and
- adequately accounting for the prudent and effective management of the resources entrusted to them.

The aim of these audits is to provide the Legislature with independent assessments about whether government programs are implemented and administered economically, efficiently and effectively, and whether Members of the Legislative Assembly and the public are being provided with fair, reliable accountability information with respect to organizational and program performance.

In completing these audits, we collect and analyze information about how resources are managed; that is, how they are acquired and how they are used. We also assess whether legislators and the public have been given an adequate explanation of what has been accomplished with the resources provided to government managers.

Focus of Our Work

A performance audit has been described as:

...the independent, objective assessment of the fairness of management's representations on organizational and program performance, or the assessment of management performance,

against criteria, reported to a governing body or others with similar responsibilities.

This definition recognizes that there are two forms of reporting used in performance auditing. The first—referred to as attestation reporting—is the provision of audit opinions as to the fairness of management's publicly reported accountability information on matters of economy, efficiency and effectiveness. This approach has been used to a very limited degree in British Columbia because the organizations we audit do not yet provide comprehensive accountability reports on their organizational and program performance.

We believe that government reporting along with independent audit is the best way of meeting accountability responsibilities. Consequently, we have been encouraging the use of this model in the British Columbia public sector, and will apply it where comprehensive accountability information on performance is made available by management.

As the performance audits conducted in British Columbia use the second form of reporting—direct reporting—the description that follows explains that model.

Our "direct reporting" performance audits are not designed to question whether government policies are appropriate and effective (that is achieve their intended outcomes). Rather, as directed by the Auditor General Act, these audits assess whether the programs implemented to achieve government policies are being administered economically and efficiently. They also evaluate whether Members of the Legislative Assembly and the public are being provided with appropriate accountability information about government programs.

When undertaking performance audits, we look for information about results to determine whether government organizations and programs actually provide value for money. If they do not, or if we are unable to assess results directly, we then examine management's processes to determine what problems exist or whether the processes are capable of ensuring that value is received for money spent.

Selecting Audits

All of government, including Crown corporations and other government organizations, are included in the universe we consider when selecting audits. We also may undertake reviews of provincial participation in organizations outside of government if they carry on significant government programs and receive substantial provincial funding.

When selecting the audit subjects we will examine, we base our decision on the significance and interest of an area or topic to our primary clients, the Members of the Legislative Assembly and the public. We consider both the significance and risk in our evaluation. We aim to provide fair, independent assessments

of the quality of government administration and to identify opportunities to improve the performance of government. Therefore, we do not focus exclusively on areas of high risk or known problems.

We select for audit either programs or functions administered by a specific ministry or government organization, or cross-government programs or functions that apply to many government entities. A large number of such programs and functions exist throughout government. We examine the larger and more significant of these on a cyclical basis.

Our view is that, in the absence of comprehensive accountability information being made available by government, performance audits using the direct reporting approach should be undertaken on a five- to six- year cycle so that Members of the Legislative Assembly and the public receive assessments of all significant government operations over a reasonable time period. We strive to achieve this schedule, but it is affected by the availability of time and resources.

Planning and Conducting Audits

A performance audit comprises four phases of a performance audit—preliminary study, planning, conducting and reporting. The core values of the Office—independence, due care and public trust—are inherent in all aspects of the audit work.

Preliminary Study

Before an audit starts, we undertake a preliminary study to identify issues and gather sufficient information to decide whether an audit is warranted.

At this time, we also determine the audit team. The audit team must be made up of individuals who have the knowledge and competence necessary to carry out the particular audit. In most cases, we use our own professionals, who have training and experience in a variety of fields. As well, we often supplement the knowledge and competence of our staff by engaging one or more consultants to be part of the audit team.

In examining a particular aspect of an organization to audit, auditors can look either at results, to assess whether value for money is actually achieved, or at management's processes, to determine whether those processes should ensure that value is received for money spent. Neither approach alone can answer all the questions of legislators and the public, particularly if problems are found during the audit. We therefore try to combine both approaches wherever we can. However, because acceptable results-oriented information and criteria are often not available, our performance audits frequently concentrate on management's processes for achieving value for money.

If a preliminary study does not lead to an audit, the results of the study may still be reported to the Legislature.

Planning

In the planning phase, the key tasks are to develop audit criteria—"standards of performance"—and an audit plan outlining how the audit team will obtain the information necessary to assess the organization's performance against the criteria. In establishing the criteria, we do not expect theoretical perfection from public sector managers; rather, we reflect what we believe to be the reasonable expectations of legislators and the public.

Conducting

The conducting phase of the audit involves gathering, analyzing and synthesizing information to assess the organization's performance against the audit criteria. We use a variety of techniques to obtain such information, including surveys, and questionnaires, interviews and document reviews.

Reporting Audits

We discuss the draft report with the organization's representatives and consider their comments before the report is formally issued to the Legislative Assembly. In writing the audit report, we ensure that recommendations are significant, practical and specific, but not so specific as to infringe on management's responsibility for managing. The final report is tabled in the Legislative Assembly and referred to the Public Accounts Committee, where it serves as a basis for the Committee's deliberations.

Reports on performance audits are published throughout the year as they are completed, and tabled in the Legislature at the earliest opportunity. We report our audit findings in two parts: a highlights section and a more detailed report. The overall conclusion constitutes the Auditor General's independent assessment of how well the organization has met performance expectations. The more detailed report provides background information and a description of what we found. When appropriate, we also make recommendations as to how the issues identified may be remedied.

It takes time to implement the recommendations that arise from performance audits. Consequently, when management first responds to an audit report, it is often only able to indicate its intention to resolve the matters raised, rather than to describe exactly what it plans to do.

Without further information, however, legislators and the public would not be aware of the nature, extent, and results of management's remedial actions. Therefore, we publish updates of management's responses to the performance audits. In addition, when it is useful to do so, we will conduct follow-up audits. The results of these are also reported to the Legislature.